

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**3810** -62-016807  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3810**

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY				a. STATE <b>Mo.</b>		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>				c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2107 S. Grand</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2107 S. Grand</b>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		5. AGE (last birthday)	
First <b>RUTH</b> Middle <b>G.</b> Last <b>GILBERT</b>				Month <b>Apr.</b> Day <b>10</b> Year <b>1962</b>		IF UNDER 1 YEAR Months Days Hours Min.	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3-1-1885</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Commercial Artist (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Eisenstadt Jewelry Co.</b>		11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>James H. Gilbert</b>				13b. MOTHER'S MAIDEN NAME <b>Cora Gray</b>		14. NAME OF HUSBAND OR WIFE <b>Cora Gilbert 5021 Stellamac Dr. (23)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Cora Gilbert 5021 Stellamac Dr. (23)</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>420.0</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>10 years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>May, 1951</b> to <b>April 1962</b> and last saw her alive on <b>March 24, 1962</b> Death occurred at <b>10:00 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Joseph A. Smith, M.D.</b>				22b. ADDRESS <b>100 N. Euclid</b>		22c. DATE SIGNED <b>APR 11 1962</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal (Rail)</b>		23b. DATE <b>Apr. 11, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Aurora, Ill.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>APR 11 1962</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

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Rev. 4/59

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DATE AMENDED

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed R. W. Storrison

Licensed Embalmer No. 4007

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.